North Carolina Industrial Commission

IC File #_____

CLAIM BY EMPLOYEE, REPRESENTATIVE, OR DEPENDENT FOR BENEFITS FOR LUNG DISEASE

Emp. Code #_____

Carrier Code #_____

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

Social Security Number Disclosure Statement

The North Carolina Public Records Act (N.C. Gen. Stat. § 132-1.10) permits the North Carolina Industrial Commission to request a social security number from an individual when doing so is imperative to the performance of its duties and responsibilities. The purpose of requesting your social security number on this form is for the Industrial Commission to verify the correct employer with the North Carolina Department of Commerce, Division of Employment Security and to identify workers' compensation insurance coverage. The disclosure of a social security number by an individual to the Industrial Commission is voluntary. Social security numbers are confidential and exempt from public disclosure by the Industrial Commission. The Industrial Commission may not share your social security number unless otherwise permitted to do so pursuant to N.C. Gen. Stat. § 132-1.10.

Employee's Name	☐ M ☐ F / / Social Security Number Sex Date of Birth
Address	If Employee is deceased, list Personal Representative
City State Zip	Spouse's Name
( ) ( ) Employee's Home Telephone Work Telephone	Name of Attorney if represented

PRINT OR TYPE ALL ANSWERS

Notice is hereby given, as required by law, that the above-named employee sustained an occupational disease caused by exposure to: cotton dust ; silica ; asbestos ; or other substance and, if known, state substance: _____.

Date of diagnosis _____ By: Dr. _____ Attach diagnosing medical records.

Date of death, if applicable_____

List of Employer-Defendants (Attach additional pages if necessary). NOTE: While you are not required to attach your SSA Earnings Report to this form, doing so will help confirm that you have listed the correct employers on this form.

Employer Name: _____ Telephone: (___) _____ Dates of Employment _____

Address: _____ Location of Job(s) _____

City State Zip _____

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Address: _____ Location of Job(s) _____

City State Zip _____

Employer Name: _____ Telephone: (___) _____ Dates of Employment _____

Address: _____ Location of Job(s) _____

City State Zip _____

IT IS REQUIRED THAT BOTH PAGES OF THIS FORM BE COMPLETED IN ORDER TO PROCESS THIS CLAIM

FORM 18B

ATTORNEYS: FILE VIA EDFP
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML
EMPLOYEES: E-MAIL TO FORMS@IC.NC.GOV
OR MAIL TO: NCIC - CLAIMS SECTION
1235 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-1235
MAIN PHONE (919) 807-2500 HELPLINE: (800) 688-8349

Employment History, Beginning with Most Recent Employment (Attach additional pages if necessary):

Employer	From / To:	Employer's Type of Business	Employee's Job Title
If you were exposed to the listed substance(s) while working for this employer, describe in detail the exposures:			

Employer	From / To:	Employer's Type of Business	Employee's Job Title
If you were exposed to the listed substance(s) while working for this employer, describe in detail the exposures:			

Employer	From / To:	Employer's Type of Business	Employee's Job Title
If you were exposed to the listed substance(s) while working for this employer, describe in detail the exposures:			

List the names and addresses of all family physicians, treating physicians and hospitals that have provided medical services or treatment to you over a 20 year period prior to the filing of this claim.

Year	**Name**	**Address (City)**	**Purpose for which treated (if known)**

I hereby authorize the above named medical sources to disclose medical records (including images such as x-rays, CT scans, MRIs, sonograms, etc.) regarding my treatment, hospitalization, and/or outpatient care for any condition during the period(s) identified above to all parties (including insurance companies) or State agencies that may review my application for compensation. I also hereby authorize that a photocopy of this authorization be accepted with the same authority as this original. The information disclosed will be used in connection with my claim for benefits under the Workers' Compensation Act.

I understand this authorization will automatically expire when my application for benefits is finally decided.

Signature of (Check One) ☐ Employee, ☐ Attorney, ☐ Representative, or ☐ Dependent

( ) Telephone Number

Address City State Zip Date Completed

Employee should return original of this form to the Industrial Commission, furnish his/her employer with one signed copy and retain a copy.

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